



Living a Healthy Life With Chronic Conditions

Participant Information Survey

Instructions:

Please use a pen to answer the questions on both sides of this form.

Please print clearly. Mark your choice within the box, like this: ☒

Your Name: _____

1. What is your date of birth?

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

2. What is your gender?

☐ **Female**

☐ **Male**

3. Are you of Hispanic, Latino, or Spanish origin?

☐ **Yes**

☐ **No**

☐ **Unknown**

4. What is your race? (Mark all that apply.)

☐ **American Indian or Alaska Native**

☐ **Asian or Asian-American**

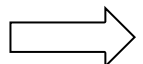
☐ **Black or African-American**

☐ **Hawaiian Native or Pacific Islander**

☐ **White or Caucasian**

☐ **Other:** _____

Please turn over



Participant Information Survey—continued

Your Name: _____

5. Has a health care provider ever told you that you have any of the following chronic conditions? (Please mark all that apply.)

- ☐ **Arthritis/ Rheumatic Disease**
- ☐ **Breathing/ Lung Disease (e.g., Asthma, Emphysema, Bronchitis)**
- ☐ **Cancer**
- ☐ **Depression or Anxiety Disorders**
- ☐ **Diabetes**
- ☐ **Heart Disease**
- ☐ **Hypertension (High Blood Pressure)**
- ☐ **Stroke**
- ☐ **Osteoporosis (Low Bone Density)**
- ☐ **Other Chronic Condition: _____**
- ☐ **None (No Chronic Conditions)**

6. What is your Zip Code?

--	--	--	--	--

7. Today, how many people live in your household (including yourself)?

--

 (Number of people)

8. Have you ever taken a chronic disease self-management workshop before?

- ☐ **Yes**
- ☐ **No**
- ☐ **Unsure**

Thank you!